IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 30, 2009

Joseph S. Bleymaier, Administrator
Emmett Rehabilitation & Healthcare, Inc
714 North Butte Avenue
Emmett, ID 83617

Provider #: 135020

Dear Mr. Bleymaier:

On **January 21, 2009**, a Complaint Investigation and State Licensure was conducted at Emmett Rehabilitation & Healthcare, Inc. Rhonda Olsen, R.N. and Lea Stoltz, Q.M.R.P. conducted the complaint investigation. A total of 8 hours were required to complete this investigation.

Surveyors interviewed the following staff: the administrator, the Director of Nursing, the Resident Services co-coordinator, one licensed nurse and one certified nursing assistant. Surveyors also interviewed four residents.

The following observations were made: 100% of residents' occupied rooms, residents in the dining and activity areas for fall prevention equipment, one resident's transfer and all residents in bed after the breakfast meal.

Surveyors reviewed the following documents: the identified resident's complete record during the most recent stay, Incident/Accident reports from October 2008 through January 19, 2009, grievance log entries from October 2008 through January 20, 2009, call light audit records from October 2008 through January 2009 and three additional complete records of residents identified as being at risk for falls.

The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003896

ALLEGATION #1:

The complainant stated that the identified resident fell from bed on November 4, 2008, at 8:30 p.m., when trying to extract a video or DVD from his television player. The complainant stated the resident did not use his call light to summon assistance because the call light was not within his reach. The call light is commonly placed near the resident's right shoulder, where he cannot reach it.

The complainant stated a visitor had witnessed the call light pinned to the uppermost right hand corner of the bed, out of reach of the resident on November 26, 2008. The complainant stated on an earlier visit, she questioned the resident about the placement of the call light button, to which the resident responded, according to the complainant, "They don't want me to have it."

FINDINGS:

An Incident/Accident report was present for the identified resident and confirmed the fall from bed on November 4, 2008. The report included investigation information supplied by staff on duty at the time of the incident. Staff reported the resident had the call light within reach at the time of the incident and that they had answered the light and asked him to wait a minute for assistance, as they were helping another resident.

When observed on January 21, 2009, from 8:15 a.m. through 10:35 a.m., the identified resident was in bed with the call light placed on his chest within reach. Call lights were within reach for all residents in their rooms during observations. The facility had instituted a random call light audit system to determine accessibility and function of call lights. They documented random weekly call light audits from October 8, 2008, through January 9, 2009. Problems with accessibility or function of the call light were not identified for this resident.

It could not be determined that the resident's call light was inaccessible at the time of the fall.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility responded to the incident described above, according to the complainant, by lowering the identified resident's bed. The facility discussed the use of the fall mat with the family, but the complainant did not know if the mat was in place at the time of the fall.

FINDINGS:

According to the November 4, 2008, Incident/Accident report, the resident's bed was in the low position at the time of the fall. The report documented the use of a mat as a potential intervention if the resident sustained further falls. At the time of the investigation, the resident had no record of further falls from bed. Neither current physician's orders nor the resident's care plan contained orders/indications for a mat on the floor at bedside. No mat was observed on the floor at bedside during the investigation. Other residents identified as being at risk for falls were observed and their records reviewed for accuracy of fall prevention interventions. No discrepancies were noted.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj